Briefing for Health & Adult Social Care Select Committee

Date: 3rd February 2022

Title: Developing Care Closer to Home – Community Hub Proposal for Thame and Marlow

Author: Karen Bonner, Chief Nurse,
David Williams, Director of Strategy, Buckinghamshire Healthcare NHS Trust

1. Introduction

The purpose of this paper is to outline a proposal to continue to operate Marlow and Thame as community hubs, with no community inpatient facilities, on a permanent basis as part of our strategy to develop care closer to home.

The proposal to pilot community hubs was agreed in 2017. Since 2017 the Trust have been working with system partners to ensure that care is delivered in the right place at the right time enabling residents to remain independent for as long as possible.

The report indicates that the previous inpatient community wards at Thame and Marlow are not suitable for delivering high quality care. The size of the previous wards at 8 and 12 beds respectively do not provide the scale to ensure sustainable staffing and due to the age of the facilities enhanced infection control standards are challenging to meet.

The report provides evidence that the additional services introduced as part of the community hubs as well as to support a 'Home First' model of care have enhanced our ability to provide safe and effective care for patients. The paper outlines plans to develop this model, and the wider development of community health services, further.

The paper provides assurance that the proposals outlined have been developed in conjunction with the Buckinghamshire Health and Social Care Committee (HASC), patients and local stakeholders.

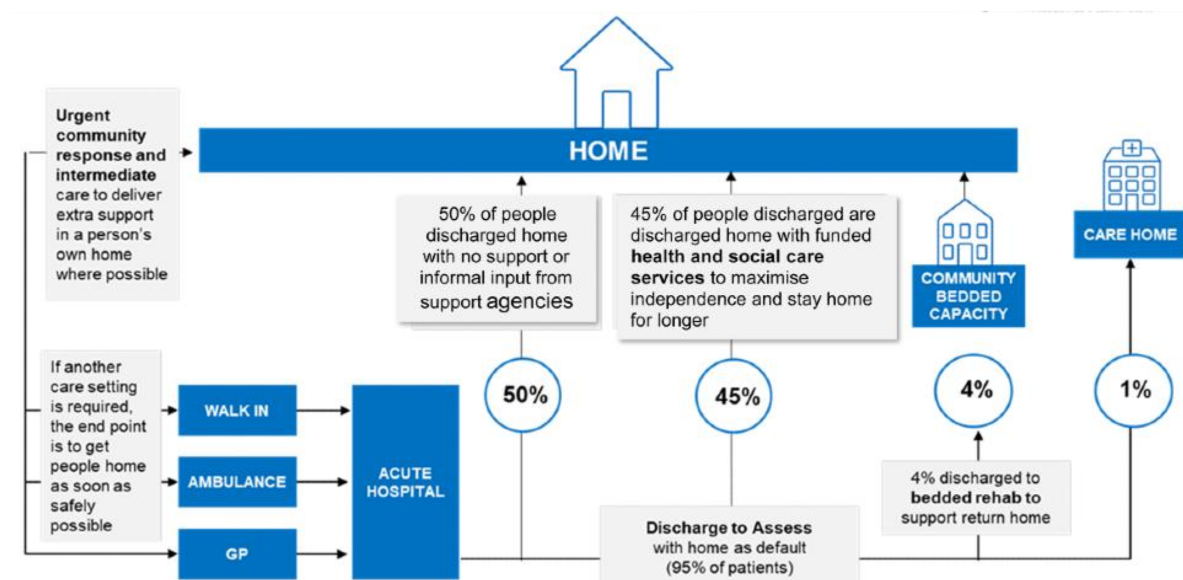
2. Background

Buckinghamshire is seeing a significant increase in the older population. It is estimated that the proportion of over 85s will increase by 38% in the county from 2022 to 2032.

There is strong evidence that for a frail, older person, a hospital admission can have a detrimental impact on their long-term health. Every ten days spent in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80[1]-. Yet each year, nationally nearly 350,000 patients spend more than three weeks in acute hospitals.

Community bedded capacity provides one of four pathways to support discharge for patients from hospital. These are outlined in a national discharge to assess pathways model along with estimated percentage of patients that require different levels of support.

Figure 1 Discharge to Assess Pathways Model [2]



3. Thame and Marlow Community Hub Proposal

In 2016 patients cared for under the '*Community bedded capacity*' pathway were delivered in four community hospitals in Buckinghamshire (Amersham, Buckingham, Thame and Marlow). A total of 80 beds. Evidence suggested that at any one time approximately 24

1

– Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

2 Hospital and Community Discharge Support, Policy and Operating Model, October 2021, NHSE

patients would have their needs better met through a different pathway outlined here as '*discharge to assess'*.

The community inpatient wards in Thame and Marlow were undersized (8 and 12 beds respectively) which presented challenges with providing the optimum skillmix of staff to maintain high quality care. A high reliance on temporary and agency staff and challenges with flexing staff led the Trust to assess alternative models to support safe and effective rehabilitation for patients.

Following engagement with patients, GPs, staff, other health and social care organisations, voluntary organisations and local communities, a community hubs pilot was launched in Marlow and Thame in April 2017 to develop and test our vision of providing more care closer to home. The aim was to enable more patients to avoid hospital admission or if a hospital admission is unavoidable, helping them to return home. The number of Buckinghamshire community beds were reduced by 20; 8 beds at Thame and 12 beds at Marlow and an alternative model of care established.

The project also improved access to outpatient and diagnostic care at Thame and Marlow providing clinics closer to local communities.

Regular updates on the impact of the community hubs in Thame and Marlow have been provided to Buckinghamshire Health and Social Care Committee (HASC) and community groups since April 2017.

4. Impact of the pandemic

The pandemic, and the disproportionate impact on the older generation, has provided further evidence of the importance of helping to keep people healthy and well and providing support and care in local communities. The average weekly duration of strength and balance activity in adults aged over 65 fell by more than one third from 126 minutes (March-May 2019) to 77 minutes (March-May 2020). The proportion of adults over age 65 performing less than 30 minutes of moderate activity per week also rose to 32% from 27% during those periods. Accordingly, Public Health England has predicted that the total annual number of falls could increase by 124,000 (6.3%) in males and 130,000 (4.4%) in females.

The pandemic has highlighted the importance of infection control. The previous community ward spaces at Thames and Marlow provide significant challenges to meet these enhanced requirements.

During the pandemic, some of our outpatient clinics were delivered virtually for the safety of our patients and our colleagues. Going forward, we will continue to offer our patients a choice of virtual or face to face outpatient appointments based on clinical need and patient preference. The Community Assessment and Treatment Service (CATS) was also suspended during the two pandemic waves so that colleagues could be redeployed to support patients in our acute hospitals. These services were re-established in March 2021.

5. How we have developed the care closer to home model since the pilot was launched

Since the community hubs pilot began, additional services have been implemented to support the aim of helping people avoid hospital admissions and supporting safe discharge. Working with partners across the system, we have been working to ensure that care is delivered in the right place at the right time enabling residents to remain independent for as long as possible.

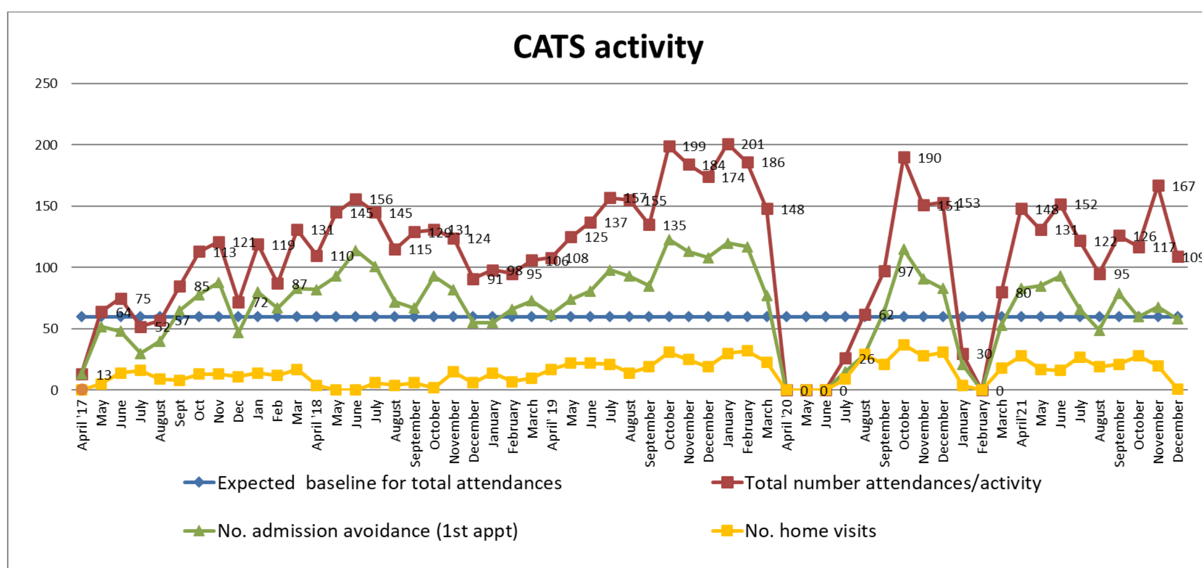
5.1 Urgent Community Response Services

5.1.1 Community Assessment and Treatment Service

The Community Assessment and Treatment service (CATS) is a multi-disciplinary rapid access service with geriatrician, nurse, GP and therapy input, supporting patients stay at home. Over 100 patients a month are seen across the two sites with an estimate of over 80 admissions to hospital avoided per month since March 2021.

The service was suspended at critical points during the covid response to enable re-deployment of specialist staff to support acute colleagues. In between these responses the service recovered quickly and regained its momentum in seeing patients. This is illustrated in the chart below:

Figure 2 CATS Activity April 2017-December 2021



A previous report in October 2018 demonstrated the reduced cost of an attendance at CATs compared to a community inpatient admission. The CATS service was able to see 131 patients in March 2018 compared to 23 community inpatients in the previous March. This demonstrates better value for money for NHS resources in the new model of care.

Following the pilot of the CATS service at Marlow and Thame, a similar service has been established at Amersham Hospital.

5.1.2 Urgent Community Response

Our ability to support patients with urgent needs in the community has been further enhanced by expanding our ability to provide urgent, crisis response care within two-hours and support discharge into the community within two-days.

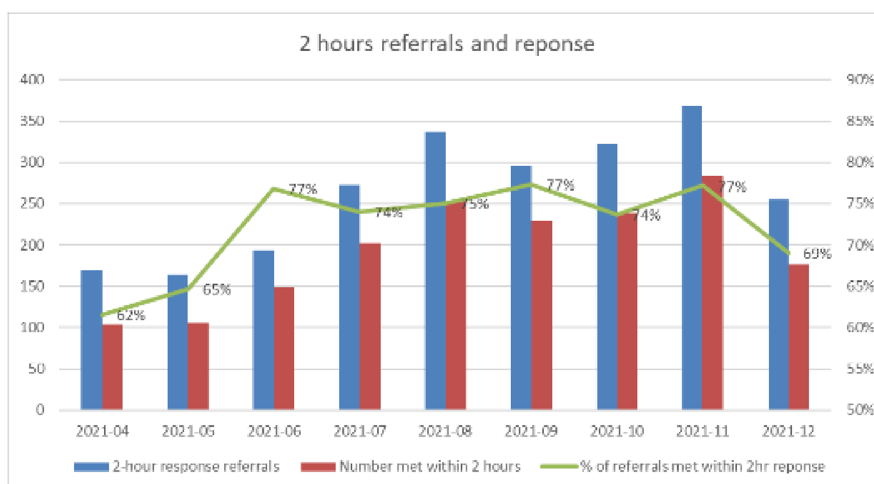
In partnership with social care, a two-hour urgent community pilot between 1 October 2020 and 31 March 2021 across three of the seven Rapid Response Intermediate Care (RRIC) teams in Aylesbury, Thame and Wycombe was introduced. This 'Ageing Well' service was enhanced to reduce preventable hospital admissions by keeping people in crisis in their home environment and facilitate swift discharges from A&E as soon as it was safe to do so, back to a patient's normal place of residence.

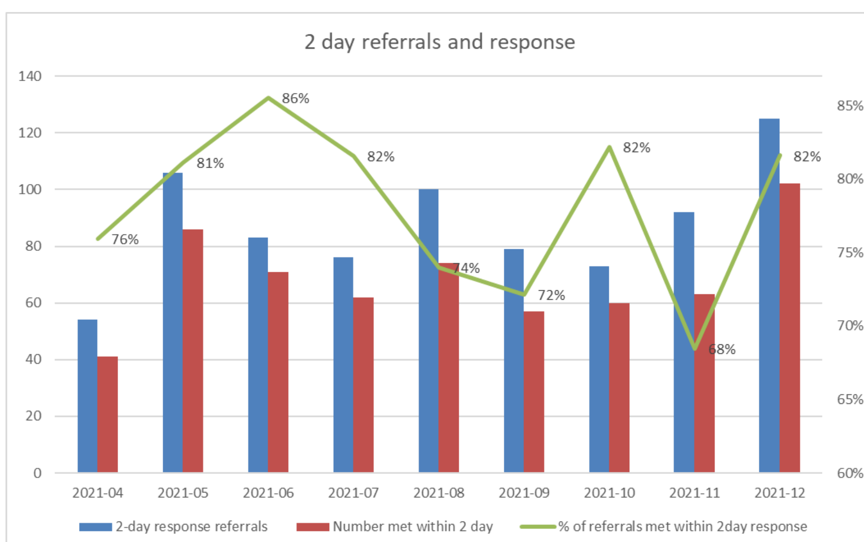
The pilot focused on two care areas:

- an enhanced therapy-led two-hour urgent community response for people at home
- an enhanced multidisciplinary rapid community response in care homes comprising of doctors, nurses and other health and care professionals working together to provide tailored support to help people live well and independently at home for longer.

Performance measures for Ageing Well are outlined below showing a steady increase in referrals in 2021.

Figure 3 Ageing Well Performance Indicators





5.1.3 Same Day Emergency Care (SDEC)

The Frailty SDEC Service was launched in November 2020. Following a GP referral or triage in A&E this new unit enables patients to be rapidly assessed, diagnosed and treated by a multidisciplinary team of doctors, nurses and therapists without the need for a hospital admission or waiting to be seen in A&E. Frailty SDEC is the provision of same day care for emergency older patients who would otherwise be admitted to hospital. Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided. The community hubs enable prompt and well-informed referrals to SDEC if a patient requires a higher level of intervention but not admission and facilitates early and supported discharges by way of intermediate care, rapid testing further assessment and health monitoring in the community. The service reviews up to 10 patients a day, reducing the need for admission and facilitating safe and assisted return to home.

Some patients do require a more intensive and supported assessment and the community hubs are also able to refer patients either at triage or directly to our Multi-disciplinary Assessment Service (MuDAS) at Wycombe Hospital, which provides easier geographical access for the south of the county.

5.2 Discharge to Assess (D2A)

The Trust continues to advocate a ‘Home First’ approach, providing patients with support for safe discharge. Patients are supported to return to their home for on-going assessments on their needs in the community after a hospital stay. As shown in the model above 45% of patients require additional health and care services to support discharge home.

Buckinghamshire has implemented a Discharge to Assess Model (D2A) where discharge to home is the default pathway (with alternative pathways for people who cannot go straight home). This makes sure assessment of ongoing needs can take place in the community rather than in a hospital setting which is national best practice and better for patients in

terms of recovery. It ensures that patients are placed in the most appropriate setting for their care needs.

Since March 2020, Buckinghamshire have commissioned an additional 159[3] beds to support patients where no further clinical intervention is required so that patients can be assessed appropriately for home support.

5.3 Impact of Discharge to Assess Pathways in Buckinghamshire

The table below highlights the positive impact of the introduction of the discharge to assess model. Whilst overall discharges are reduced the total bed days occupied have reduced by 17.9% and 35.3% amongst those patients staying greater than 21 days, offering the hospital 8900 additional bed days from just the 21+ day group, which even allowing for the reduction in overall volume of patients is still more than 900 additional bed days per month (which is more than 30 beds available each day). Overall length of stay for patients has also reduced.

Table 1 Impact on D2A Model in Buckinghamshire

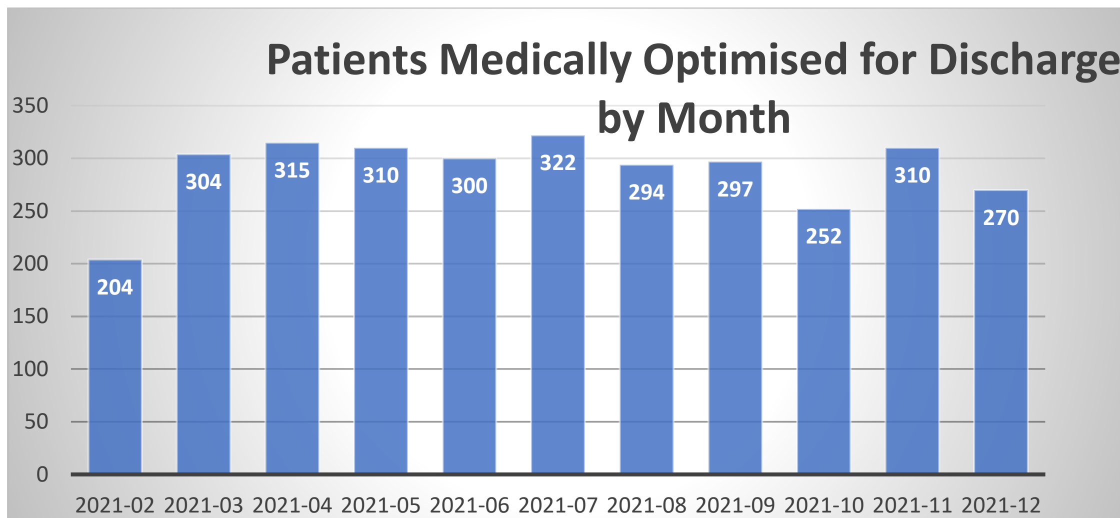
Ref	Description	2019-20 (M1-M4) D2A	2021-22 (M1-M4) D2A	Change	Change (%)
A	Total patients discharged	6251	5564	687	11.0%
B	Number of discharges LOS <21 days	5585	5064	521	9.3%
C	Number of discharges LOS 21< days	666	500	166	24.9%
D	Bed days occupied by patients LOS >21 days	25200	16300	8900	35.3%
E	Total Bed Days - All D2A	53700	44100	9600	17.9%
F	Average Length of Stay - All D2A	8.6	7.9	0.7	7.7%

Table 1 – Key discharge volume and bed day statistics

The number of patients who are medically fit for discharge home is a measure of community support. The monthly figures for the number of patients residing in hospital waiting for domiciliary, social, community, discharge to assess and care home support is highlighted below.

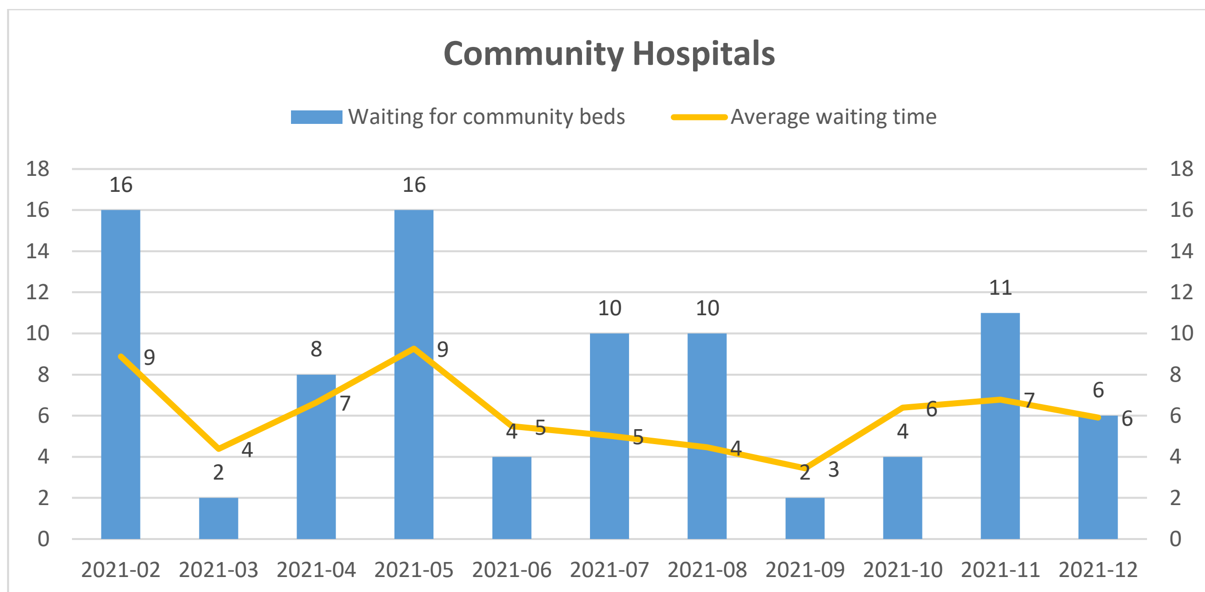
[3] 77 Discharge to Assess beds and 82 ‘spot purchased beds’ in the community

Figure 4 Buckinghamshire - Patients Optimised for Discharge by Month 2021



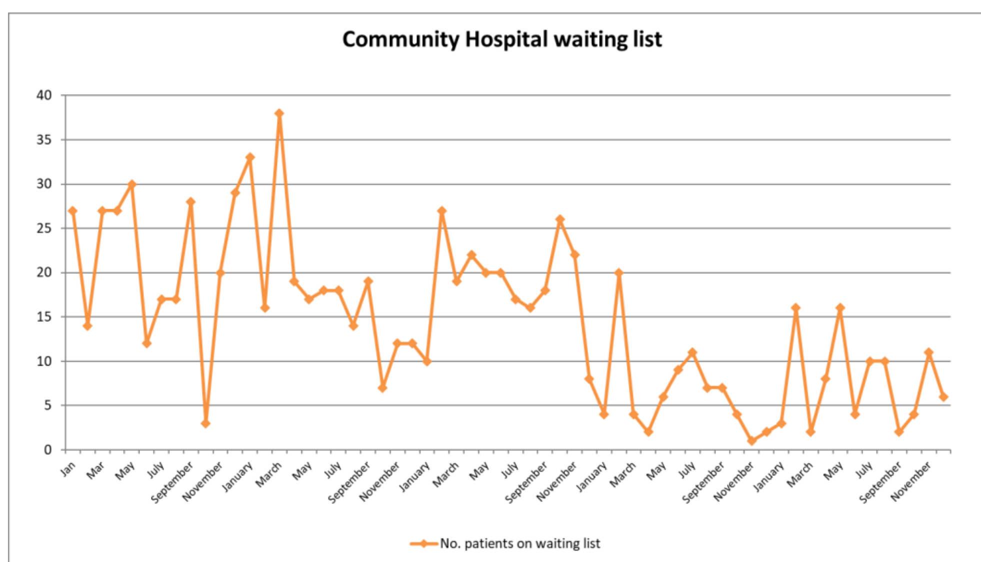
The patients waiting for community beds during this period is highlighted below.

Figure 5 Community Hospital – Number of patients waiting for community beds and average waiting time 2021



The figures above can be compared with previous years which has shown a gradual reduction in the number of patients waiting for community beds since 2017 as other services and support has become available in the Buckinghamshire system.

Figure 6 Community Hospital Waiting List January 2017-December 2021



The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services is a good measure of the support the Buckinghamshire health and care system provide to support patients in their own home after a hospital stay. This measure has improved year on year since 2016/7 against a Buckinghamshire local target of 75%.

Table 2 Rehabilitation Performance Measures

2016/17	2017/18	2018/19	2020/21
66%	72%	77%	87.9%

5.4 Future Plans for Home First, Discharge to Assess and Intermediate Care

There is clear evidence of better patient outcomes and experience as a result of Home First. All healthcare systems are expected to embed home first and discharge to assess as a default process for hospital discharge[4].

Given the introduction of new services a full demand and capacity model has been developed for Buckinghamshire for discharge pathways into community beds, care homes and discharge to assess pathways. The model predicts that community support for the system will increase by 16% over the next five years.

'Real time' scorecards have been developed which will enable services to match and flex their capacity to meet demand and to have visibility across all discharge pathways improving patient outcomes and experience.

[4] NHS Operating Plan Guidance, 2022/23, NHSE, Dec 2021

This model is forming the basis of a business case to develop a single integrated pathway for Buckinghamshire residents delivered across multi-disciplinary teams drawn across health and social care, including a proposal for future provision of bedded capacity across all settings. This will enable:-

- More efficient and cost-effective models of care and ways of working
- Dedicated beds for step up and step down
- Reducing in admissions and speeding up of D2A process
- Reduction on reliance on spot bed purchases

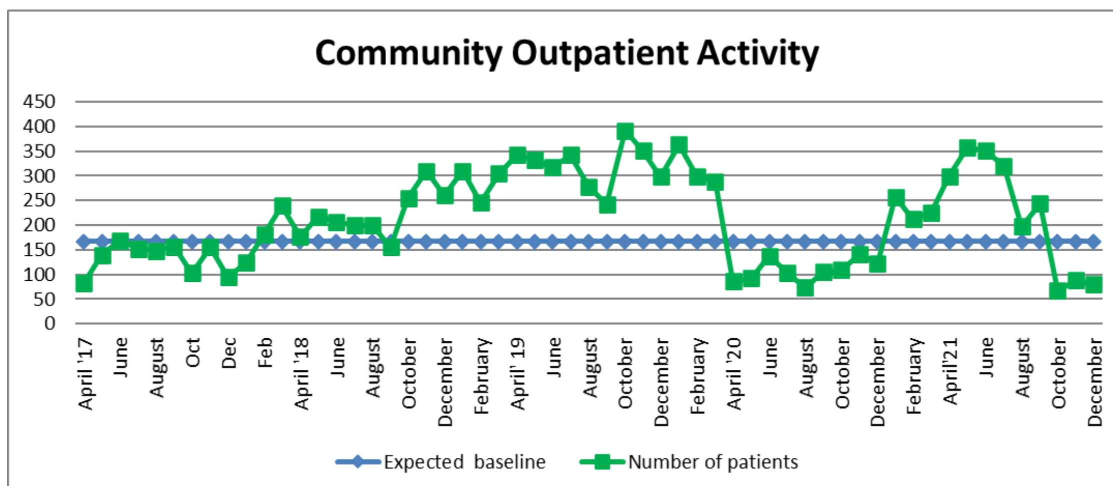
This case will be developed during 2022/23, learning from the changes instigated by the pandemic and will provide further assurance to system partners and the HASC that we are providing effective support to keep our patients safe and supported at home and on discharge from hospital care.

6 Outpatients and Diagnostic Services

6.1 Outpatient clinics

One of the aims of the pilot, was to increase the number of outpatient clinics available in local communities so that patients do not have to travel to one of our main hospitals. The chart below illustrates the increasing use (pre-covid) and the re-establishment of clinics since April 2021.

Figure 5 Community Outpatient Activity April 2017-December 2021



We are currently working closely with clinicians to further expand the range of outpatient clinics we are able to offer at Thame and Marlow.

Table 3 Comparison of outpatient clinics at Thame and Marlow Hospitals

Previous Thame Outpatient Clinics	Current Thame Outpatient Clinics
Rheumatology Physiotherapy Urology Heart failure Diabetes Speech and language X ray Blood tests ENT Respiratory Dermatology	Health visiting BCG Clinic Paediatric audiology Bereavement counselling Practice Plus Physiotherapy Podiatry Falls Specialist Clinic CATS Continence clinic Heart Failure clinic Plastics Pulmonary Rehabilitation Thame Day Hospital Ultrasound Tissue viability Hip and Knee team AAA screening Cancer Support Cancer Care Warfarin

Previous Marlow Outpatient Clinics	Current Marlow Outpatient Clinics
Rheumatology Physiotherapy Urology Heart failure Diabetes Speech and language X ray Blood tests ENT	Health visiting BCG Clinic Cancer Care Cancer support Oncology Physio Palliative care Physiotherapy Dietetics Podiatry Tissue Viability Vascular Falls Specialist Clinic CATS Continence clinic Heart Failure clinic Diabetes AAA Screening Warfarin Clinic Oral Surgery

6.2 Diagnostics

As well as the X-Ray facility at Marlow (which has not been operational during the pandemic due consolidating staffing in our main hospitals), an ultrasound scanner purchased by the local League of Friends has been installed at Thame since September 2019. Since the ultrasound scanner became operational, over 2,600 scans have been performed and it has remained operational throughout the pandemic. The Trust's diagnostic capacity will be further strengthened through the establishment of an expanded Community Diagnostic Hub (CDH) which will open shortly at Amersham Hospital. Not only will this provide additional capacity, operating 12 hours a day 7 days a week, but it will also improve accessibility and take the current pressure from our acute hospital sites. In 2021/22 we will extend the hours of operation radiology examinations and in the future we plan to offer other diagnostic services including examinations and tests for heart conditions and respiratory diseases at the CDH.

7. Engagement with patients and communities

This section summarises how we have worked with patients and local stakeholders from the inception of the services to ensure that their views shaped the development. We have maintained this engagement throughout with strong support for the current community hubs.

7.1 Community Stakeholder Group

At the start of the pilot, a Community Hubs Stakeholder Group was established to provide feedback and help us to shape services and ensure they were meeting the needs of the local community. The Community Hubs Stakeholder Group comprises of representatives from the Marlow and Thame League of Friends, local GP Patient Participation Groups, Buckinghamshire Older People's Action Group, local councillors as well as members of the general public. The Group has continued to meet on a regular basis and continues to provide valuable feedback to inform our plans and areas of focus. The Group has been supportive of the Community Hubs project and representatives from the Marlow and Thame League of Friends contributed letters of support in a report which went to HASC in April 2018 and are attached as Appendix 1.

In October 2021 a meeting with the Community Hubs Stakeholder Group reconfirmed support for the community hubs model to continue and to permanently close the community beds at Thame and Marlow.

In addition, continued engagement has taken place with the Bucks Older Peoples Action Group (BOPAG). A statement from the Chair of the Group in January 2021 also endorses our approach as Appendix 1.

7.2 General Public

In addition to the initial engagement that took place prior to the start of the community hubs pilot, we have continued to seek the views of the general public and key stakeholders as we have developed our community model of care.

Early in 2018 a series of workshops took place across the county to report back on what had been achieved in the pilot hubs in Thame and Marlow and gather their views on what care closer to home could look like across Buckinghamshire. The community hub model of care, received broad support across all stakeholder groups involved in the review. Whilst highlighting some issues regarding public awareness of the hubs and transportation issues, the consensus was that people wanted to see the current hubs continue and for model to be rolled out across Buckinghamshire, with provision tailored to needs in different areas. An evaluation report was submitted to HASC in April 2018.

7.3 Buckinghamshire Integrated Care Partnership Survey

In August 2020 we, along with our partners from the Integrated Care Partnership, launched phase 1 of a public engagement programme to ask people what they thought about changes we have made, or are considering, in health and social care. The engagement was designed with support from the Getting Bucks Involved Steering Group which includes members of patient participation groups, representatives from local charities and Healthwatch as well as members of the public. One of the themes was regarding community services, seeking views on organisations working together to promote independence and delivering care in people's home and communities.

Phase 1 was a survey which gathered data from over 2,800 respondents; the majority of whom were white females with an average age of 60. Whilst the concept of community hubs was now well known, the idea was well received with 66% of respondents saying that they would prefer to recover at home than in a hospital if it was safe to do so. Phase 2 was designed to actively seek representation from a diverse range of Buckinghamshire residents, especially groups who are not often reached by such research, such as people living in areas of deprivation. Participants in these focus groups expressed a need for beds to be available to support people who, whilst medically fit, could not be discharged from hospital to their homes.

7.4 Service Users

In the 12 months (2019/2020) pre COVID-19 we had 100% of patients rating the CATS service as good or excellent.

Feedback received since the service has resumed include:

“Everybody was so helpful, and the advice and assistance has changed my life. Nothing was too much trouble and I had as much time as I needed.”

“I went home not quite fixed but having taken the first steps along the road. Thank you”

“You gave me a great uplift with all the checks, tests and information I could have wished for.”

Frailty SDEC, MuDAS and Ageing Well projects have been well received by patients who have articulated the impact of the high quality care received. Friends and family surveys across these services indicate a high level of satisfaction from the patients who have used these services.

7.5 Statutory Bodies

In November 2021 Buckinghamshire Clinical Commissioning Group (CCG) Governing Body supported the recommendation to continue with the community hubs in Thame and Marlow on a permanent basis as did the Buckinghamshire Healthcare NHS Trust Board in January 2022.

7.6 Buckinghamshire Health and Social Care Committee (HASC)

Continued liaison has taken place with the Buckinghamshire Health and Social Care Committee (HASC) and assurances and evidence are attached to this paper following discussions with HASC members. Members were particularly keen to seek reassurance that there were no current plans to reduce the provision of community inpatient beds at Buckingham Community Hospital. The Trust can provide this assurance. The HASC will be communicated with on any significant service change proposed in future ensuring the appropriate engagement with patients and the public takes place.

Additional evidence and assurance attached to this paper is as follows:

- Appendix 1: Letters of Support from Community Stakeholder Groups and Chair and the Bucks Older People Action Group (BOPAG)
- Appendix 2: Orthopaedic and Stoke Community Pathways
- Appendix 3: Initial Equality Impact Assessment from the community hub pilot - April 2018

8. Recommendations

In summary, the previous community inpatient wards at Thame and Marlow are not suitable or sustainable for community inpatient care.

Keeping people healthy and independent in their own homes with the support from community hubs at Thame and Marlow is clinical best practice, delivers better outcomes, improves access and has been developed with patient and local stakeholder input.

We propose continuing with the current model of care in the community, including the community hubs at Marlow and Thame, on a permanent basis and not reintroduce the community inpatient beds on these sites as they are no longer fit for purpose.

We will continue to focus on further developing the closer to home model by

- Developing a business case by September 2022 with partners to support a sustainable Intermediate Care model of care in Buckinghamshire
- Continue to support urgent community response initiatives to prevent unnecessary hospital admissions
- Continued development of virtual outpatient appointments
- supporting primary care to proactively identify patients who may benefit from being

referred to the CATS service and ultimately avoiding a hospital admission
- exploring the feasibility of developing additional community hubs across the county

We will engage with the Community Hubs Stakeholder Group, HASC and the wider community as we continue to develop the community model of care.

Karen Bonner
Chief Nurse

David Williams
Director of Strategy

January 2022

EVIDENCE AND ASSURANCE APPENDICES

Appendix 1

Support statement from Patrick Land on behalf of the Marlow Hospital League of Friends

In relation to the Community Hubs Pilot, on behalf of the Marlow Hospital League of Friends I would like this statement of support to be taken into account when considering the future steps in relationto the Community Hub Pilot Scheme. In the Marlow community there has been great anxiety following the closure of the beds in the Marlow Community Hospital some while ago. This was followed by the appearance of the "closure" of the Hospital, which caused very significant local concern. I, together with fellow representatives of the Marlow Hospital League of Friends, and otherrepresentatives of the Marlow community including the Mayor have attended regularly at the Community Hubs Pilot Stakeholder Group meetings, at which we have been able to be appraised of the latest developments through the course of the Pilot Scheme, and have been able to be involved in discussions in relation to the Community Hubs Pilot. As far as we have been able, we have reported back to the local community.

The view of the Marlow Hospital League of Friends is that the Community Hub Scheme is a positive step which has the potential to be developed considerably, and as such also has the potential to be welcomed widely by the healthcare professionals involved in the delivery of the services, and also bythe community will be able to recognise the constructive use of the much valued Marlow Community Hospital as an integral part of the delivery of a modern healthcare service in the locality.

The Marlow Hospital League of Friends very much hope that it will soon be possible to remove the word "Pilot" from the Community Hub Scheme, and for there to be significant ongoing progress in the rolling out of the various services that can be provided from the Community Hub in Marlow, together with the co-ordination with and mobilisation of additional sectors including the voluntary sector to maximize the potential for the services that can be delivered from the Community Hub, and to support the scheme in ways which are appropriate to the Marlow Hospital League of Friendsas a local charity.

We await news of the outcome of recent discussions with anticipation.

Support statement from Sarah Taylor, Chair of Thame Hospital League of Friends

The establishment of the pilot scheme for the Health Hub in Thame means that, for the first time in years, the League of Friends of Thame Community Hospital is feeling cautiously optimistic about thefuture of their hospital. Indeed, there is growing enthusiasm for the project in the wider Thame community.

The hospital had always been associated with beds, originally used for a mixture of respite and patients needing overnight monitoring. Over the years, the number of beds had

dwindled to a levelthat was not financially viable and the small number of beds meant that, more often than not, theywere occupied by patients from outside Thame: they couldn't be kept free on the off chance that aThame patient might need one. Although there was a lot of activity at the hospital, we lived in constant fear of the place being closed altogether.

The growing consensus that frail elderly patients should be kept out of hospital and at home for aslong as possible has in fact potentially given our hospital a new lease of life.
What we want is a hospital that is there for the people of Thame and surrounding areas and is, in modern parlance, sustainable. That is, it should have a role that is genuinely useful and affordable for the long term. The current pilot scheme offers the vision of just such a role, combining as it does:the excellent CATS (community ambulatory treatment service) which assesses vulnerable patients and provides solutions to keep them at home and prevent admission to A&E; the existing physiotherapy service; the Day Hospital providing rehabilitation and preventative treatments; an increased number of clinics provided by consultants and other healthcare professionals coming fromStoke Mandeville and the John Radcliffe Hospital; input from the voluntary sector such as Carers Buckinghamshire and Oxfordshire; support from the neighboring GP practices; more diagnostic services in the community; facilities for the Day Centre. The Buckinghamshire Healthcare Trust that runs the Hospital is working closely with stakeholder groups to adapt to local needs and break downbarriers between Hospital and the Community.

Of course, these are early days, and all is by no means perfect. We must work hard to ensure that all the GPs in the locality use the services to help make them viable and that patients are aware of whatis on offer and push to be referred to the hospital rather than have to go further afield for assessment and treatment. The hospital needs investment in better IT and better equipment.

Recruiting staff in an area where housing is so expensive remains a perennial problem. The GPs nextdoor are bursting at the seams and need bigger premises. The transition between healthcare and social care is desperately short of the mark. Keeping people at home only works if there is support for them and their carers. We all must work towards finding solutions to these problems.

We have been given a commitment that, should the pilot fail, the beds will be restored, and the hospital returned to what it was. However, we all know that that is not viable in the long run. Therefore, as a League, we are keen for the pilot to be successful and to be confirmed as the policy for the future.

Support statement from Alan Barnard, Chair of Bucks Older people Action Group (BOPAG)

Alan Barnard has provided the following statement of assurance from a BOPAG and Valley Plus perspective:

> As the Chairman of Valley Plus, (the Marlow Bottom Older Persons Action Group) and BOPAG (Buckinghamshire Older Peoples Action Group) I have represented them at Stakeholder meetings since the early days of the pilot. initially, there were strong local feelings against the closure of the hospital beds and the change of use. Since seeing the evidence presented of the progress being made and personal involvement, I have become a firm advocate of the Hub service, in particular the CATS. The sooner this can become more widely used by the local GP's to refer patients the better this will be, likewise greater use by the Ambulance Service in preference to taking patients to distant A & E services (both Stoke Mandeville and Wexham Park being difficult to reach by public transport from Marlow). I am sure there is room for further services such as blood testing, X-ray (although only basic equipment), ENT, Urology and in particular Dementia would be greatly appreciated locally.
>
> Both Valley plus and BOPAG have given the BHS a number of opportunities to present the purpose and progress of the project at our meetings, which has been very well received. BOPAG's monthly magazine which is widely distributed to older people throughout the area, online and hard copy, has given wide coverage to the projects progress and is readily available to assist in the future.
>
> It is unfortunate that the Covid 19 pandemic has overshadowed and hindered much of the progress of the project, with closures and a slowdown of HNS services. However, now that the scheme is planned to become a permanent one enabling progress on alterations and signage can be made.
>
> The closure of the inpatient beds, so far, seems to passed with little negative impact, a number of people I have consulted were not even aware of any closure, so perhaps once Covid infections become much less of a problem greater attention could turn to more publicising the Hub and getting greater public awareness, in the meantime we look forward to working with BHT in the future for the success of the project.